ACTION: Voted to inform State Department of Public Health that C.M.A. declines to participate in the proposed format, but prefers the outline previously submitted to Health, Education and Welfare by the California Medical Education and Research Foundation.

Recessed: 10:30 p.m., November 16, 1963.

Reconvened: 10:00 a.m., November 17, 1963.

23. Bureau on Communications:

REPORT: Doctor Warren Bostick, chairman, presented a summary of BUCOM's activities in a slide-illustrated talk and outlined broad policy goals. He described the preliminary plans of the Inter-Agency Council on Smoking, which includes American Cancer Society, California Heart Association, State Tuberculosis Association, Department of Education, State Department of Health and the C.M.A. He requested authorization for continued participation in this group's activities by the C.M.A.

ACTION: Voted that C.M.A. should continue such participation.

24. Internal Communications on Legislation:

REPORT: Problems of reaching the membership with matters concerning governmental activities affecting medicine were discussed by Doctor Malcolm Todd, chairman of the California Volunteers for the American Medical Political Action Committee and Mr. Ben Read, executive director of the Public Health League.

ACTION: Voted to ask the Medical Executives Conference to study improved means of reaching the "grass roots" of medicine with information concerning legislative matters; that special consultation be held with the elected secretaries of component societies not having executive secretaries.

25. Guiding Principles for Physician-Hospital Relationships:

(a) *Further Implementation of the Program*

SUMMARY: Doctor MacLaggan, pointing out the backlog of 40 staff requests for surveys and reviewing the time required to organize and conduct such surveys, recommended that the C.M.A. employ an individual, preferably a physician, to coordinate this endeavor.

ACTION: Voted that the executive director be authorized to consider and employ such a person at his discretion.

(b) *Distribution of Survey Responsibilities*

SUMMARY: Doctor MacLaggan described the difficulty of covering the entire state in such surveys using only the members of the Liaison Committee to the California Hospital Association.

ACTION: Voted to permit use of physicians other than members of the Liaison Committee to assist in some surveys when additional assistance is needed.

26. Review of Council Agenda and Procedures:

SUMMARY: Discussion touched on many facets of Council procedure. Consideration was given to the present structuring of the Council on a basis proportionate to membership and to the possibility of revising this formula . . . to the matter of invited guests and reports by them . . . to perhaps more detailed reporting of the Council minutes . . . to more detailed advance information on agenda matters . . . to means of more adequately anticipating time for discussion of local councilor district matters . . . of perhaps verbatim tape-recording of Council meetings.

ACTION: Voted that the chairman appoint an ad hoc committee on Council Procedures to make recommendations on all matters pertaining to Council efficiency.

ACTION: Voted that representatives of affiliated organizations be kept informed that they are welcome to attend all Council meetings, but that they need not make reports except on specific invitation of the Committee on Emergency Action and staff or if they wish to initiate such action by prior information to the C.M.A.

ACTION: Voted to tape-record and use public address equipment for the next meeting of the Council.

Adjourned: 1:05 p.m., November 17, 1963.

CARL E. ANDERSON, M.D., *Chairman*
MATTHEW N. HOSMER, M.D., *Secretary*

Kerr-Mills Administration in California

SAMUEL R. SHERMAN, M.D.*

I APPRECIATE this opportunity to appear before you and present the views of the California Medical Association on the various subjects you have listed on your agenda concerning implementation of the Rattigan-Burton Act in California.

My name is Samuel R. Sherman, and I practice medicine in San Francisco. I am president of the California Medical Association and former chairman of the Council of the Association. I have also been a member of the Medical Care Advisory Committee to the State Department of Social Welfare since its

*A statement by the President of the California Medical Association, before the California Senate Fact Finding Committee on Labor and Welfare, December 12, 1963.

inception in 1957, and have been chairman of that committee for over two years.

I have read the transcript of the hearings held on October 24, 1963, in San Francisco. I hope I can clarify and more sharply define some of the issues discussed with you at that time, in order that the position of the California Medical Association may be clearly understood. I am aware, as you are, of the events leading up to the enactment of the Rattigan-Burton Act and subsequent amendments. The history of this program outlined by the associate administrative analyst, Mr. Vonn Damm, is brief and concise. I would like to add, however, that after the passage of Kerr-Mills and before the Rattigan-Burton Act was written, we proposed to a special committee that was established to study and recommend ways to implement Kerr-Mills in California, that broad coverage prepaid health insurance should be provided for those eligible for Medical Assistance for the Aged. A special proposal by California Physicians' Service was presented to this committee.

The legislative proposal that was finally presented — the Rattigan-Burton Bill — was understood by all to be a first step toward implementation of the Kerr-Mills Law. It was the best compromise available at the time. No one knew, for instance, how large a group of people might need assistance. As has been stated before, this bill, which later became law, recognized that the most costly care confronting the greatest number of people over 65, was long-term, chronic care in hospitals and nursing homes. The old definition of acute care was that requiring less than 30 days' confinement; chronic care was defined as that requiring 30 or more days of confinement. The bill that was finally enacted did provide a very broad and comprehensive program for this particular area of need.

If, in any way, the impression has been created that the people who carry out the mandate of the legislature have been less than energetic in implementing it, or are unsympathetic to it, I want to say without hesitation, I do not share this view. The personnel of the State Department of Finance and the State Department of Social Welfare, and the county welfare departments, are a dedicated and devoted group of public servants, trying their best within the framework of the laws and regulations under which this program operates, to administer it for the benefit of those who need help. There may be differences of opinion, but there can be no room for suspicion or rancor when people of good will undertake a common cause.

During the first twelve months that this program was in operation, it provided hospital and nursing home care for 27,539 different persons; 23.8 per cent of those helped were not receiving public assistance of any type. It is fair to say that the new group of people intended to be covered by Kerr-Mills, constituted no more than 23.8 per cent of those who received care under the Rattigan-Burton Act during the first twelve months of its operation.

As a result of the experience under the Rattigan-Burton Act during the first year, the California Medical Association recommended that the eligibility requirements pertaining to personal property holdings be expanded to include more people who ought to be eligible for care under Kerr-Mills. C.M.A. also requested that provision be made to pay for acute as well as chronic care; i.e., that the 30-day waiting period be repealed and, in its stead, a dollar deductible be adopted. It was suggested that this dollar deductible might be somewhere in the area of $300 to $500. A statement containing these recommendations was made to the Assembly Committee on Social Welfare in December of 1962.

The 1963 session of the legislature amended the Rattigan-Burton Act by adopting Assembly Bill No. 59. This Act makes payment for acute care available in county hospitals from the first day of admission, but does not make provision for payment of such care in voluntary hospitals until after 30 days of confinement or the expenditure of $2,000.

Gentlemen, I feel this is special legislation, inducing, if not forcing, people to obtain governmentalized medical care. It is discriminatory. It violates the original concept of the law which allowed free choice of facility.

Further, the effect of this law was to provide a large windfall to those counties having a county hospital. In other words, counties were already obligated to provide hospital care for welfare recipients 65 and over and were now enabled to recoup from the Federal Government one-half the cost of that care. Most of this windfall was to be used to make more money available for the recipients of Aid to Children of Dependent Families. While the latter program is a very laudable one, it has nothing to do with providing medical care for those 65 and over who are able to care for their ordinary needs but not for extensive medical expenses. In essence, this is denying care for Peter in order to provide care for Paul.

Let me give you another example of taking care of other groups with MAA funds. Admittedly, some of the older people in mental health facilities need not be there and could be cared for in nursing homes. When they are in mental health facilities, the state is obligated to pay for their care. It is now proposed that those who are 65 and over be shifted to and made eligible for, Medical Assistance for the Aged and be placed in nursing homes. As they have already spent 30 days in a hospital, care would be

paid for from the first day of confinement in a nursing home. One-quarter of the cost would be paid by the state, instead of the whole cost of their care; the counties would pay one-quarter, instead of none; and the Federal Government would pay one-half. I submit that the congressional intent of Kerr-Mills was stretched almost to the breaking point by the unique and imaginative approaches outlined above. The amendments contained in Assembly Bill No. 59 really did not provide payment for medical care needs of the new group which Congress tried to provide for under Kerr-Mills, except to a very slight degree. It is the failure to provide care for this group that I want particularly to emphasize.

This committee and others have raised the question, is this type of implementation — this shifting of a substantial part of the OAS load to MAA — consistent with the intent of Congress as expressed in Kerr-Mills? Technically and in a narrow sense, this is a legal question and I am not competent to answer it for I am a physician, not a lawyer. From all I have read and heard, I think it is factual to say, as the lawyers put it, there seems to be a split of opinion. Problems concerning administration also complicate this matter.

Items 2(b) and 2(c) of your agenda, it seems to me, call for a *practical reexamination of this problem* rather than a technical, legalistic approach to it, and I think this is important.

Item 2(c) asks, "Should Medical Assistance for the Aged be amended to meet the medical needs of our aged persons with greater economical means, and if so, how?" I take it that this refers to those individuals who are not on welfare. This question must be answered in the affirmative. To me, it is the real heart and core of the problem.

Item 2(b) asks the question, "Should the simultaneous receipt or shifting of Medical Assistance for the Aged, Aid to the Blind, Aid to the Disabled and OAS, be permitted?" If something isn't done about 2(c), extending care to the medically indigent, then question 2(b) definitely must be answered "no."

The C.M.A. favors providing for payment of the extensive medical care needs for the new group of people described in Kerr-Mills — those who are otherwise able to take care of themselves. I believe that the legislature also is in favor of gradually providing care for this group. So far, the only care provided has been tied to the needy aged. We should make payment for medical care available to the low-middle income group. The personal property limitation needs to be amended and revised. For MAA recipients, the amount of personal property reserve ought to be raised from $1200 for a single person to $3600 or $5,000, and for a married couple from $2,000 to $5,000 or $10,000. Sufficient income to pay for extensive medical care needs should be the principal criteria. Until this problem of eligibility is grappled with, whatever redirection of the program you recommend will be virtually ineffective as far as helping this new group is concerned.

If this concept of assistance for this new group is not implemented, the whole program that was started with such great hope goes sadly awry, at least as it relates to those it was primarily intended to cover, and it ought therefore to be abandoned. On November 16, 1963, the California Medical Association Council adopted the following recommendations to be presented to this committee:

1. That the Department of Social Welfare be urged to cease and desist from providing medical care with MAA funds for citizens who have recently been recipients of Old Age Security.

2. That the Rattigan Act be amended to read, "to meet the health needs of aged persons who are not *and have not recently been* recipients of Old Age Security."

3. That the Rattigan Act be amended to read that its purpose is "to furnish medical assistance on behalf of *aged individuals* who are not (and have not recently been) recipients of Old Age Assistance, but whose income and resources are insufficient to meet the costs of necessary medical services."

4. That the requirement that a patient spend a month in a private hospital before becoming eligible for Kerr-Mills funds be eliminated.

5. That the requirement that a patient in a private hospital pay $2,000 before becoming eligible for Kerr-Mills funds be eliminated, and that the criterion be that point in the payment for private care when the individual's income and resources become insufficient to meet the costs of necessary medical services.

6. That the time a private patient spends with his own finances in a private hospital before he becomes eligible for Kerr-Mills assistance, be reduced to, or preferably below, the time an indigent spends in a county hospital before the County Treasury becomes eligible for compensation for his care.

7. That the fees paid to private hospitals for MAA patients be at least adequate to meet the costs of providing the services, and that they be no less than the fees paid by other state agencies for the same service.

8. As soon as feasible, the insurance principles should be extended to the administration of medical care under the MAA program.

If, however, the California law is amended so as to provide care for this new group both in nursing homes and in hospitals, then the true intent of the Kerr-Mills Law would be served, and until Congress provides more adequate matching medical care

funds for OAS, I personally would not oppose the same level of matching funds for the needy as for the near-needy.

We have proposed before that a reasonable dollar deductible be used instead of 30 days' confinement in a hospital or nursing home, as a condition of eligibility. The present $2,000 "corridor" is completely unrealistic when one realizes that it is required of a person who cannot have $1200 worth of personal property including money in the bank. If payment for the first day of care is to be provided in county hospitals, it should also be provided in voluntary hospitals.

You have taken much testimony on the matter of adequate rates. We most emphatically support the concept that the state ought to allow the payment of adequate rates to hospitals, nursing homes, dentists, physicians and others, in order to assure the availability of quality care. This is a complex problem and the legislature needs to become involved with it. We can all agree that the highest-cost facilities, such as a single hospital room for all cases, need not be provided. At the same time, the rate structure should not be tied to the lowest available. This matter calls for a policy decision by the legislature, to direct that the usual or prevailing rates be paid.

Some people will say that the things I am recommending will cost money and the governor is committed to a policy of no increase in state taxes. You are entitled to know our position on this matter of taxes.

In general, we are not in favor of high taxes, but we are in favor of taxes to provide sufficient money to take care of the health needs of the needy and the near-needy aged. If more taxes will be required, let's provide them. In a letter to me recently, Mr. J. M. Wedemeyer, director of the Department of Social Welfare, estimated that to provide free choice of hospital for acute care under the present law, using a $500 deductible, the program might cost six million dollars a year. This would mean a million-and-a-half dollars of state money, the same amount from the counties and three million dollars from the Federal Government. I would hope that Governor Brown might be convinced that he should favor such a comparatively small expenditure. The newspapers report that last month he told the House Ways and Means Committee that they should increase the taxes on all working people and employers to the extent of one-half of one per cent in order to provide nursing home and hospital care for all people 65 and over. This would take out of California over 200 million dollars. It is hard for me to understand why it is right to advocate a 200 million dollar federal tax on Californians and wrong to seek to raise one-and-a-half million dollars in state taxes. Why is it urgent to pay for hospital care for all persons 65 and over through federal taxation, whether or not they need assistance, but not urgent to help, at state level with matching federal funds, those who need some assistance when confronted with a large hospital bill?

In conclusion, I want to recommend again the use of broad coverage, prepaid health insurance for MAA beneficiaries, particularly those needing acute hospital care. Almost three-fourths of the population of this country possesses health insurance. The legislature has provided it for state employees; mechanisms are already established to administer it. Its use by MAA recipients would ensure the provision of the same type of care, service and rates as are received by others in the community. The one area in which voluntary health insurance has had its greatest experience, is in hospital coverage. The county welfare department need not concern itself with this administrative function.

This year saw the beginning, on a pilot basis for the recipients of public assistance care in Santa Barbara County, of the use of the prepaid mechanism, underwritten by the physicians of that county and California Physicians' Service. More than two-thirds of the physicians in the county provide professional services to the welfare recipients. The program is operating successfully and administrative costs are reported as being kept at a minimum. The Welfare Study Commission has recommended the extension of the use of broad coverage health insurance.

May I again express my appreciation to you for the opportunity to discuss these most important matters. I would welcome any questions you might have.